

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445490	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/21/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  AVE MARIA HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2805 CHARLES BRYAN RD BARTLETT, TN 38134
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 170 483.10(i)(1) RIGHT TO PRIVACY -  
SS=C SEND/RECEIVE UNOPENED MAIL

The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.

This REQUIREMENT is not met as evidenced by:

Based on interview, it was determined the facility failed to ensure residents' mail was promptly delivered on Saturdays for 75 of 75 residents residing in the facility.

The findings included:

During an interview in Administrator's office on 8/21/13 at 5:00 PM, the Administrative Assistant stated, "Mail is delivered here on Saturdays to the front desk and it is placed in my office and on Mondays I put it [mail] in the "Activities Box" and they distribute it [mail] out to the residents..."

During an interview in the activities department office on 8/21/13 at 5:15 PM, the Activities Director confirmed that no mail was delivered to the residents on Saturdays.

F 309 483.25 PROVIDE CARE/SERVICES FOR  
SS=D HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

F 170 Residents will continue receiving mail on Saturdays or when the mail is delivered by the Post Office. The manager on duty will deliver the mail to the appropriate resident. The Activity Director will monitor through a resident satisfaction questionnaire annually. Results will be reported to the Quality Assurance Committee. 9/02/13

Administrator will monitor for compliance.

F 309 Ave Maria Home will continue to ensure physician orders (PO) are obtained and followed.

Plan of Correction: The physician order for Resident #70 was obtained on 3/26/2013 for an orthotic device to be used when up in wheelchair at all times. On 8/22/2013 a new order was received to discontinue the orthotic device after the DON discussed the use of the device

*Francis J. Satterthwaite*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Evelyn P. Smith*  
TITLE DATE 9/5/13

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

*This same POC was faxed 9/5/13*

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445490	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/21/2013
NAME OF PROVIDER OR SUPPLIER  AVE MARIA HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2805 CHARLES BRYAN RD BARTLETT, TN 38134	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 309	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure physician's orders were followed for an orthotic device or medication for 2 of 17 (Residents #70 and #93) sampled residents of the 28 residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>Review of the facility's "Physician Medication Orders" policy documented, "...Medications shall be administered... upon the written order of a person duly licensed and authorized to prescribe such as medications in this state..."</li> <li>Medical record review for Resident #70 documented an admission date of 7/10/12 with diagnoses of Arthritis Rheumatoid, Atrial Fibrillation, Hypothyroidism, Hypertension, Bradycardia, Sick Sinus Syndrome, Senile Osteoporosis, Degenerative Joint Disease, Status Post Fracture Right Femoral Neck. Review of a physician's order signed 8/1/13 documented, "... PT [physical therapy] TO USE HIP/KNEE ABDUCTION ORTOSIS WHEN UP ON W/C [wheelchair] AT ALL TIMES FOR INCREASED POSITIONING OF BLE [bilateral lower extremities]..."</li> </ol> <p>Observations in the hallway on 8/19/13 at 11:10 AM, revealed Resident #70 propelling herself in a w/c with no orthotic device between her knees.</p> <p>Observations in the dining room on 8/20/13 at 8:35 AM, revealed Resident #70 propelling herself in a w/c with no orthotic device between</p>	F 309	<p>with the Physical Therapist and MD. For Resident #93 the MD and NP were made aware that the PO was not processed correctly and a new order was received to administer the Seroquel 12.5 QHS for early morning behaviors.</p> <p><u>Preventative Action:</u> All elders with devices will be added to the Restorative Nursing program to ensure placement of devices according to MD orders, In addition, the Certified Nursing Assistant care plan will be updated quarterly by the MDS nurse and ADON, or her designee. The 10p-6a charge nurse was in-serviced to check charts in the evening to ensure all orders are processed correctly and to handwrite the new order on the paper Medical Administration Record. The 10p-6a charge nurse is also to check the e-Link for the eMar program to ensure all new orders are processed. The eMar program has a new Orders Administration system that Ave Maria Home will convert to by 9/16/2013. This program is an update to the current system and provides a means for the pharmacy and the nurses to both view the orders entered by either party.</p> <p><u>QA and Monitoring:</u> The ADON, or her designee, will randomly monitor weekly to ensure that the physician orders are being followed. The ADON, or her designee, will regularly check the e-Link weekly to ensure orders are processed through the pharmacy system accurately, and she will also randomly check the e-Mar weekly to monitor for accuracy of the orders. The DON will</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445490	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/21/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  AVE MARIA HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2805 CHARLES BRYAN RD BARTLETT, TN 38134
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 309 Continued From page 2  
her knees.

Observations in Resident #70's room on 8/21/13 at 9:30 AM, revealed Resident #70 sitting in a w/c with no orthotic device between her knees.

Observations in the hallway on 8/21/13 at 2:20 PM, revealed Resident #70 in a w/c with her knees together, her left foot on the floor and her right foot on the pedal of the w/c. There was no orthotic device between her knees.

During an interview in the conference room on 8/21/13 at 2:30 PM, the Director of Nursing (DON) was asked if a hip knee abduction ortosis should be present when Resident #70 is up in a w/c. The DON stated, "...let me ask the therapist if this is a current order or if it [the order] has not been taken off... I have not seen this on her..."

During an interview in the conference room on 8/21/13 at 2:50 PM, the DON confirmed the order for the orthotic was a current order.

3. Medical record review for Resident #93 documented an admission date of 7/23/13 with diagnoses of Alzheimer's Disease, Chronic Atrial Fibrillation, Diabetes Mellitus and Depressive Disorder. Review of a physician's order dated 7/31/13 documented, "...Seroquel 12.5 mg [milligrams] HS [hour of sleep] for early AM behaviors..." The electronic Medication Administration Record (MAR) dated July and August 2013 revealed no documentation that Resident #93 ever received Seroquel 12.5 mg at HS from July 31 through August 20, 2013 (21 days).

Review of the admission Minimum Data Set

F 309 monitor for compliance.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445490	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/21/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  AVE MARIA HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2805 CHARLES BRYAN RD BARTLETT, TN 38134
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 309	<p>Continued From page 3</p> <p>(MDS) dated 7/31/13 documented a Brief Interview for Mental Status score of 0, indicating the resident's cognition was severely impairment. This MDS documented the presence of physical behavioral symptoms directed toward others which put the resident at significant risk for physical illness or injury and significantly interfered with the resident's care. The resident's behavior put others at significant risk for physical injury and significantly disrupted care and the resident rejected evaluation or care 4 to 6 days out of the last 7 day look back period.</p> <p>Review of the "Behavior Roster" dated 7/30/13 at 3:23 AM, documented "...Behavior noticed... Yes, behavior noted... Describe behavior... Kicking others..."</p> <p>During an interview in the legacy house hallway on 8/20/13 at 4:20 PM, Nurse #1 was asked about Resident #93's behaviors. Nurse #1 stated, "[Resident #93] can get agitated in the morning..."</p> <p>During an interview in the legacy house nurses' station on 8/21/13 at 1:25 PM, Resident #93's Nurse Practitioner confirmed she wrote the order for Seroquel on 7/31/13 based on a report from staff about Resident #93 displaying behaviors.</p> <p>During an interview in the DON's office on 8/21/13 at 1:30 PM, the DON confirmed Resident #93 did not receive Seroquel 12.5 mg at bedtime. The DON was asked to find documentation that Resident #93 had received Seroquel. The DON stated, "...I would have to agree... I do not see it [that Seroquel was on the MAR]..."</p>	F 309		
-------	---	-------	--	--

RECEIVED  
SEP 06 2013